Understanding Your Diagnosis and Care Needs

cancer.org | 1.800.227.2345

NAME ______________________________

DOB ______________________________

My cancer

Type of cancer: ______________________________

Date of diagnosis: ___ / ___ / _____

Symptoms I have from my cancer: ______________________________

____

Stage of cancer: ______________________________

- Where in my body is the cancer? ______________________________
- Has the cancer spread? ☐ Yes ☐ No
- To where? ______________________________

More test results for my cancer, if done:

- Pathology results ______________________________
- Biomarker or molecular testing ______________________________
- Genetic testing ______________________________

Family history of cancer (see attachment)
Medicines and supplements I take (see attachment)

Other testing and consults

Tests I will need, including where and when they will be done

- Imaging tests: ______________________________
- Blood tests: ______________________________
- Other tests: ______________________________

Name and contact information for other cancer specialists I will need to see

- Surgeon: ______________________________
- Radiation oncologist: ______________________________
- Medical oncologist: ______________________________
- Other doctor or specialist: ______________________________

Treatment options

What is the goal of my treatment? __________

What are my treatment options? __________

What does my cancer care team recommend? __________

What will happen if I choose not to get treated now, or at all? __________

Advance directives

- ☐ Living will
- ☐ Durable power of attorney for health care
- ☐ POLST (Physician Orders for Life-sustaining Treatment)
- ☐ DNR (Do not resuscitate) orders
- ☐ Organ and tissue donation

If you have these documents, be sure to give a copy to your cancer care team. If you'd like to learn more about them, ask your cancer care team or go to **cancer.org/advancedirectives**.

Cancer care team

Treatment facility or clinic: __________

Medical record/patient number: __________

Contact information for my cancer care team

- Doctor or facility name: __________
- Main contact (such as navigator, nurse, nurse practitioner, physician assistant): __________
- Business hours phone number: __________
- After hours phone number: __________
- Can I contact my team through an online patient portal? ☐ Yes ☐ No

Supportive and palliative care

- Expected side effects and management plan: __________
- Effects on fertility (for those of childbearing age): __________
- Resources for mental health care, like support groups and counseling: __________
- Recommended diet and physical activity before and during treatment: __________

Treatment options

- Insurance company name and contact information: ______
- Type of insurance plan (HMO/PPO): ______
- Is my cancer doctor part of my insurance plan? ______
- How much of the cost of treatment will my insurance cover? ______
- How much will I need to pay out of pocket for copays, co-insurance, or deductibles? ______
- Will I have other costs or fees like parking and housing during treatment? ______
- What financial assistance or payment plans might be available? ______
- Financial counselor or social worker contact: ______

Daily responsibilities

- What daily tasks will I need help with? ______
- Will I be able to work or go to school during treatment? Will I need to ask for changes or extra help? ______
- If I need to take leave from work, will I be eligible for Family and Medical Leave Act (FMLA)? ______
- Will I need someone to give me rides to treatment? ______

Resources

- Cancer Care Toolkit (CCT) – **cancer.org/cct**

Attachment: Family History
Attachment: My Medicines
Attachment: Appointments and Questions
Attachment: My Lab Results

Cancer Family History Questionnaire

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NAME ___________________________

DOB ___________________________

Have you ever been diagnosed with cancer? ☐ Yes ☐ No

Have you or any of your relatives ever had genetic testing? ☐ Yes ☐ No
Any follow-up? Please give details:

Biological Family History:
Please fill out the following information where it applies to your biological family only.

	Type(s) of Cancer	Age(s) at Diagnosis	Current Age
You			

Immediate Family	Total Number	Number with Cancer	Type(s) of Cancer	Age(s) at Diagnosis	Current Age	Age at Death
Your Daughter(s)						
Your Son(s)						
Your Brother(s)						
Your Sister(s)						

PATERNAL RELATIVES	Type(s) of Cancer	Age(s) at Diagnosis	Current Age(s)	Age(s) at Death	Ethnicity
Your Father					
Your Father's Father					
Your Father's Mother					

	Total Number	Number with Cancer	Type(s) of Cancer	Age(s) at Diagnosis	Current Age(s)	Age(s) at Death
Your Father's Sister(s)						
Your Father's Brother(s)						
Paternal Cousin(s)						
Half Brother(s) or Sister(s) from your Father						

MATERNAL RELATIVES	Type(s) of Cancer		Age(s) at Diagnosis	Current Age(s)	Age(s) at Death	Ethnicity
Your Mother						
Your Mother's Father						
Your Mother's Mother						
	Total Number	Number with Cancer	Type(s) of Cancer	Age(s) at Diagnosis	Current Age(s)	Age(s) at Death
Your Mother's Sister(s)						
Your Mother's Brother(s)						
Maternal Cousin(s)						
Half Brother(s) or Sister(s) from your Mother						

Other Relatives

Relationship to you (i.e., niece, nephew, halfsibling, etc.)	Type(s) of Cancer	Age(s) at Diagnosis	Current Age(s)	Age(s) at Death

Additional Notes:

My Medicines

Use this form to keep track of your medicines, including their dose and when to take them.

Medicine	Reason for taking	Prescribed by	Dose	When to take	Notes

My Appointments and Questions

Use this form to record your appointments and questions you would like to ask your health care provider.

Date	Time	Appointment with	Phone	Notes/Questions

My Lab Results

Use this form to keep track of your lab test results, as well as any notes about your labs.

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Test	Reference or normal range	Date:	Date:	Date:	Date:	Notes/Questions
		Test result	Test result	Test result	Test result	

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